Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935

1400 E. Washington Avenue
Madison, WI 53703

FAX #: (608) 261-7083
Phone #: (608) 266-2112

E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

MEDICAL EXAMINING BOARD

INFORMATION FOR COMPLETING THE APPLICATION FOR A RESIDENT EDUCATIONAL LICENSE

PLEASE PLAN AHEAD:

Applicants, recruiters, institutions, and others involved in the placement of individuals who seek to be credentialed in the state of Wisconsin should understand that the credentialing process takes time and that credentialing is not guaranteed to any applicant. Factors that determine the length of time it may take to process an application include the length of time the applicant has been in practice, the total number of jurisdictions in which the applicant has been credentialed, and the length of time it takes for supporting documents to be received in the Board office and reviewed.

The application consists of an all-inclusive packet with instructions and information on all applicable requirements. We strive to process applications in a timely fashion. We cannot issue a credential until all of the required documents have been received and reviewed in the Board office.

It is the Department's mission and legislative mandate to provide consumer protection for Wisconsin residents. The Department and the Board have been asked to waive requirements to expedite the process, only to discover legitimate grounds to deny a credential. This can present a serious problem for the applicant, recruiter or institutions if the applicant has relocated, purchased property, or made other commitments prior to the issuance of a Wisconsin credential. **We urge you not to make these moves until you know that your credential has been issued**. Please "plan ahead" as we cannot speed up the credentialing process or waive supporting documents even in emergency situations.

This license is designed for an applicant who has been accepted into a post-graduate training program in a facility in this state approved by the board under the provisions of Wis. Admin. Code Med 5.02.

AN APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

- Completed application form and fee (Form #564)
- Certificate of Professional Education (Form #3050)
- Affidavit of Hospital Authority (Form #2601)

MAILING INSTRUCTIONS: Mail the Application for Licensure, the appropriate fee, and documentation to the following address:

MAILING ADDRESS:
DSPS
ATTN: MEDICAL EXAMINING BOARD
P.O. BOX 8935
MADISON WI 53708-8935

EXPRESS DELIVERY:
DSPS
ATTN: MEDICAL EXAMINING BOARD
1400 E. WASHINGTON AVE
MADISON WI 53703

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CODES FOR SPECIALTIES: Enter specialty code(s) on page 1 of the Application.

Academic Medicine	37	Otolaryngology	67
Administrative Medicine	71	Otorhinolaryngology - ENT	15
Aerospace Medicine	33	Pain	66
Alcoholism - Chemical Dependency	49	Pathology	16
Allergy - Immunology	01	Pathology - Clinical	17
Anesthesiology	02	Pathology - Surgical Anatomic	72
Aviation Medicine	32	Pediatrics	18
Dermatology	03	Pediatrics - Other	60
Emergency Medicine	31	Perinatology	62
Endocrinology	56	Pharmacology - Clinical	48
Family Medicine	925	Physical Medicine and Rehabilitation	19
Gastroenterology	06	Preventive Medicine	09
General Practice	08	Proctology	36
Genetics	61	Psychiatry	20
Geriatrics	29	Psychiatry - Child	21
Hand Surgery	64	Public Health	22
Hebiatrics	46	Radiation - Oncology	70
Hematology	07	Radiology	53
Hyperbaric Medicine	65	Radiology - Diagnostic	43
Immunology - Infectious Diseases	47	Radiology - Nuclear Medicine	68
Institutional Medicine	39	Radiology - Ultrasound	69
Internal Medicine	04	Research	34
Internal Medicine - Cardiology	05	Retired	24
Internal Medicine - Pulmonary Medicine	45	Rheumatology	57
Neonatology	63	School Physician	52
Nephrology	40	Surgery - Cardiovascular	44
Neurology	10	Surgery - Colon and Rectal	54
Neuromuscular Medicine	926	Surgery - General	25
Neurophysiology	51	Surgery - Maxillofacial	58
Nuclear Medicine	23	Surgery - Neurological	11
Obstetrics and Gynecology	12	Surgery - Peripheral Vascular	59
Occupational Medicine	30	Surgery - Plastic	26
Oncology	38	Surgery - Thoracic	27
Ophthalmology	13	Urology	28
Orthopedic Surgery	14		

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APPLICATION FOR RESIDENT EDUCATIONAL LICENSE

Under Wisconsin law, the Department must deny your application if you are liable for delinquent State Taxes or Child Support (Wis. Stat. § 440.12).

PLEASE TYPE OR PRINT IN INK

☐ Your name and address are available to the public. Check box to withhold street address/PO Box number from lists of 10 or more credential holders (Wis. Stat. § 440.14).

Last Name	First Name	MI	Former / Maiden Name(s)

Address (street, city, state, zip)

Daytime Telephone Number ___ - ___ - ____

Mailing Address (if different)

Date of Birth ___ / ___ / ____

Social Security # ___ - ___ - ____

Your Social Security Number or Employer Identification Number must be submitted with your application on this form. If you do not have a Social Security Number, you must complete Form #1051. The Department may not disclose the Social Security Number collected except as authorized by law.

Ethnicity/gender status information is optional.

Ethnicity:
☐ White, not of Hispanic origin
☐ Black, not of Hispanic origin
☐ American Indian or Alaskan
☐ Asian or Pacific Islander
☐ Hispanic
☐ Other

Sex: ☐ M ☐ F

Email Address:

Medical School:

School Address:

Degree:

Date Degree Granted: ___ / ___ / ____

Specialty: (see page ii for a list of codes)

Specialty Code: ___

For Receipting Use Only (851)

APPLICATION FEES: Please check box. Make check payable to DSPS and attach to this application.

Required DSPS Fee - $10.00

Committed to Equal Opportunity in Employment and Licensing

Wisconsin Department of Safety and Professional Services

POST-GRADUATE TRAINING/FELLOWSHIPS, PRACTICE, AND OTHER ACTIVITIES: List in chronological order from the date of graduation of medical school to the present time. Below information **must include professional and nonprofessional activities**. **(Attach additional sheets if necessary using the same format.)**

DATES (Month, Year)	**TYPE**	**NAME OF SCHOOL, HOSPITAL CLINIC OR OTHER**	**LOCATION** (City, State and Country)
(From) ☐☐ / ☐☐ (To) ☐☐ / ☐☐	☐Post Grad ☐Intern ☐Resident ☐Fellow ☐Practice ☐Other		City) (State) (Country)
(From) ☐☐ / ☐☐ (To) ☐☐ / ☐☐	☐Post Grad ☐Intern ☐Resident ☐Fellow ☐Practice ☐Other		City) (State) (Country)
(From) ☐☐ / ☐☐ (To) ☐☐ / ☐☐	☐Post Grad ☐Intern ☐Resident ☐Fellow ☐Practice ☐Other		(City) (State) (Country)
(From) ☐☐ / ☐☐ (To) ☐☐ / ☐☐	☐Post Grad ☐Intern ☐Resident ☐Fellow ☐Practice ☐Other		City) (State) (Country)
(From) ☐☐ / ☐☐ (To) ☐☐ / ☐☐	☐Post Grad ☐Intern ☐Resident ☐Fellow ☐Practice ☐Other		City) (State) (Country)
(From) ☐☐ / ☐☐ (To) ☐☐ / ☐☐	☐Post Grad ☐Intern ☐Resident ☐Fellow ☐Practice ☐Other		City) (State) (Country)

ECFMG Exam Taken? ☐ Yes ☐ No

Certificate Issued? ☐ Yes ☐ No

Certificate #: ______

Date Issued: ☐☐ / ☐☐ / ☐☐☐☐

Wisconsin Department of Safety and Professional Services

ANSWER THE FOLLOWING QUESTIONS: (Attach additional sheets if necessary)

1.	Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health regarding communicable diseases?	Yes ☐ No ☐
2.	Have you ever surrendered, resigned, canceled, or been denied a professional license or other credential in Wisconsin or any other jurisdiction? **If yes, give details on an attached sheet, including the name of the profession and the agency.**	Yes ☐ No ☐
3.	Have you ever failed to pass any State Board, National Board (NBME or NBOME), FLEX, or USMLE Examination? **If yes, provide details below:**	Yes ☐ No ☐
4.	Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to any warning, reprimand, suspension, probation, limitation, or revocation? **If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.**	Yes ☐ No ☐
5.	Is disciplinary action pending against you in any jurisdiction? **If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.**	Yes ☐ No ☐
6.	Have you ever been convicted of a misdemeanor or a felony, or do you have any felony or misdemeanor charges pending against you? **If yes, submit Convictions and Pending Charges (Form #2252).**	Yes ☐ No ☐
7.	Are you incarcerated, on probation, or on parole for any conviction**? If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.**	Yes ☐ No ☐
8.	Have any suits or claims ever been filed against you as a result of professional services? **If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition and complete Malpractice Suits or Claims (Form #2829).**	Yes ☐ No ☐
9.	Have your hospital privileges ever been limited or removed? **If yes, give details on an attached sheet**.	Yes ☐ No ☐
10.	Are you registered or licensed in any other profession(s)? **If yes, state what profession(s) and in what state(s):**	Yes ☐ No ☐
11.	Have you ever been credentialed under any other name(s)? **If yes, state name(s) credentialed under:**	Yes ☐ No ☐
12.	Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? **If yes, give details on an attached sheet.**	Yes ☐ No ☐

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, Cerebral Palsy, Epilepsy, Muscular Dystrophy, Multiple Sclerosis, cancer, heart disease, Diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, Tuberculosis, drug addiction, and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years.**

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. Heroin or Cocaine) as well as the use of controlled dangerous substances, which are not obtained pursuant to a valid prescription, or not taken in accordance with the directions of a licensed health care practitioner.

Wisconsin Department of Safety and Professional Services

ANSWER THE FOLLOWING QUESTIONS: (Attach additional sheets if necessary)

13.	Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? **If yes, please explain.**	Yes ☐ No ☐
14.	Does your use of chemical substances in any way impair or limit your ability to practice medicine with reasonable skill and safety? **If yes, please explain**.	Yes ☐ No ☐
15.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? **If yes, please explain.**	Yes ☐ No ☐
16.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? **If yes, please explain.**	Yes ☐ No ☐
17.	Have you ever been diagnosed as having or have you ever been treated for Pedophilia, Exhibitionism, or Voyeurism? **If yes, please explain.**	Yes ☐ No ☐
18.	Are you currently engaged in the illegal use of controlled dangerous substances?	Yes ☐ No ☐
19.	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? **If yes, please explain.**	Yes ☐ No ☐

CERTIFICATION OF LEGAL STATUS:

I declare under penalty of law that I am (check one):

- ☐ A citizen or national of the United States, or
- ☐ A qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. Seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at http://www.uscis.gov.

Should my legal status change during the application process or after a credential is granted, I understand that I must report this change to the Wisconsin Department of Safety and Professional Services immediately.

CONTINUING DUTY OF DISCLOSURE

I understand that I have a continuing duty of disclosure during the application process. If information I have provided in this application becomes invalid, incorrect or outdated, I understand that I am obliged to provide any necessary information to ensure the information on my application remains current, valid, and truthful. I understand that Credentialing authorities may view acts of omission as dishonesty and that my duty of disclosure during the application process exists until licensure is granted or denied.

AFFIDAVIT OF APPLICANT

I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of a credential may result in credential application processing delays; denial, revocation, suspension or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. I further understand that if I am issued a credential, or renewal, or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause of disciplinary action.

By signing below, I am signifying that I have read the above statements (Certification of Legal Status, Continuing Duty of Disclosure and Affidavit of Applicant) and understand the obligation I have as an applicant or credential-holder should information I've provided to the Department of Safety and Professional Services change.

Applicant Signature: _____ Date: _____